THREE R'S SCHOOL ENROLLMENT FORM

CHILD'S NAME			BIRTHDATE
CHILD'S HOME ADDRESS			HOME PHONE
MOTHER'S NAME			CELL PHONE & PROVIDER (FOR DAYCARE MESSAGES)
MOTHER'S HOME ADDRESS			ZIP
EMPLOYED BY			WORK PHONE
ADDRESS			ZIP
DRIVER'S LICENSE #	DATE OF BIRTH	SOCIAL SECURITY # ___ ___	EMAIL - MOTHER
FATHER'S NAME			CELL PHONE & PROVIDER (FOR DAYCARE MESSAGES)
FATHER'S HOME ADDRESS			ZIP
EMPLOYED BY			WORK PHONE
ADDRESS			ZIP
DRIVER'S LICENSE #	DATE OF BIRH	SOCIAL SECURITY # ___ ___	EMAIL- FATHER

PERSON TO CALL IN CASE OF EMERGENCY IF PARENTS/GUARDIAN CANNOT BE REACHED:	TELEPHONE NO.	RELATIONSHIP

I HEREBY AUTHORIZE THE DAY CARE FACILITY TO RELEASE MY CHILD TO THE FOLLOWING PERSONS. INCLUDE NAMES AND PHONE NUMBERS:

DATE OF ADMISSION/ WITHDRAW	HOURS AND DAYS CHILD WILL BE IN CARE	MEALS TO BE SERVED TO MY CHILD __ALL MEALS SERVED __BREAKFAST __AM SNACK __LUNCH __PM SNACK __DINNER

List any special problems that your child may have, such as allergies, food intolerances, existing illness, previous serious illness, injuries during the past 12 months, limitations or restrictions on child's activities, any medication prescribed for long-term continuous use, reasonable accommodations or modifications, adaptive equipment, symptoms or indications of complications, and any other information which staff should be aware of:

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:

NAME OF LICENSED PHYSICIAN	ADDRESS	TELEPHONE NO.
OR TO (NAME OF HOSPITAL OR CLINIC)	ADDRESS	TELEPHONE NO.

I give my consent for necessary emergency treatment when my child is in the care of this physician and/ or hospital/clinic.

Signature - Parent or Legal Guardian _____ Date _____

TRANSPORTATION: I hereby ☐ give ☐ do not give my consent for my child to be transported and supervised by facility's staff:

☐ On Field Trips ☐ To and From Home ☐ To and From School ☐ For emergency care

WATER ACTIVITES: I hereby ☐ give ☐ do not give my consent for my child to participate in the following water activities:

☐ water table play ☐ sprinkler play ☐ aquatic playgrounds

Parent's Comment: _____

3. **SCHOOL-AGE CHILDREN:** My child attends:

NAME OF SCHOOL	SCHOOL'S TELEPHONE NO.

My child's immunization record is on file at the school and all immunizations and tuberculosis test results are current. Signature - Parent or Legal Guardian

_____

Signature and Date

PARENT'S ACKNOWLEDGMENT: I acknowledge receipt of THREE R'S SCHOOL " Parent Handbook". This includes the Operational Policies. I received a tour of the facility. The following topics were discussed:

Tuition Policy	Immunizations
Payment Policy	Inclement Weather
Drop off/ Pick up	Daily Schedules
Illness and Medication	Absences
Emergency Plan	Contact Information
Parent Involvement	Challenging Behaviors
Parent Conference	Discipline and Guidance
Meals and Nutrition	Parents Rights
Screen Time Policy	Parent Orienation
Child Development	TRS certification

_____ _____

Signature - Parent or Legal Guardian Date

Tuberculosis Test: To be completed if recommended for the area by the Texas Department of Health. (Day care facility staff will inform parents of these requirements.) .....

Results ☐ Positive ☐ Negative	Date

_____ _____ _____ _____

Signature (or stamp) - Physician or Health Personnel Date Signature - Staff Making Handwritten Copy of Record Date

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about_____ and does not need varicella vaccine.

ADMISSION REQUIREMENT: One of the following must be presented when your preschool-age child is admitted to the day care facility or within one week of admission. Check to indicate the option you select:

☐ **Doctor's Statement:** I have examined the above-named child within the past year and find that he/she is physically able to take part in the day care program. .....

Physician's Signature _____ Date

☐ A copy of the medical screening form of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program IF no referral for further diagnosis and treatment is indicated.

☐ A form or written statement from a health service or clinic.

If you do not have any of the above:

☐ **Parent's Statement:** My child has been examined within the past year by a licensed physician and is able to participate in the day care program:

NAME AND ADDRESS OF PHYSICIAN OR ADDRESS OF EPSDT SCREENING SITE

☐ Within the next 12 months I will obtain a physician's statement, a copy of the medical screening form from the EPSDT Program, or a form or statement from a health service or clinic and will submit it to the day care facility. **OR**

☐ My child has an appointment for a physical examination:

DATE	NAME AND ADDRESS OF PHYSICIAN OR ADDRESS OF EPSDT SCREENING SITE

I will submit the physician's statement, EPSDT form, or health service or clinic form to the day care facility following the examination

_____ _____

Signature - Parent or Legal Guardian Date

NOTE: If medical diagnosis and treatment and/or immunizations and TB testing conflict with your religious beliefs, you must sign an affidavit to that effect and attach it to this form.If immunization and/or TB testing would be injurious to your child or family, you must obtain a certificate (signed by a physician) to that effect and attach it to this form.

Three R's School

Food Allergy Emergency Plan

Child's Name:_____

Date of Enrollment:_____

Diagnosed Food Allergies: _____

_____

Symptoms of exposure to Food Allergies: _____

_____

_____

Steps to take if child is exhibiting symptoms of an allergic reaction: _____

_____

_____

_____

Parent Signature: _____ Date: _____

Parent Phone Number: _____

Health Care Professional Address and Phone Number:

_____

_____

Texas Department of State Health Services

Tuberculosis (TB) Questionnaire for Children

Name of Child _____ Date of Birth _____

Organization administering questionnaire _____Three R's School_____ Date _____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) or a TB blood test (called an IGRA) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box	**Yes**	**No**	**Don't Know**
TB can cause a fever of long duration, unexplained weight loss, a cough (lasting over two weeks), or coughing up blood. **As far as you know has your child:** • been around anyone with any of these symptoms or problems? or • had any of these symptoms or problems? or • been around anyone sick with TB?			
Was your child born in: Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to: Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries:			
To your knowledge, has your child spent time (longer than 3 weeks) with: anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? ☐ Yes (specify date ____/____/_____) ☐ No
Has your child ever had a positive TB skin test? ☐ Yes (specify date ____/____/_____) ☐ No
Has your child ever had a positive TB blood test? ☐ Yes (specify date ____/____/_____) ☐ No

For school/healthcare provider use only

****

PPD / IGRA administered (circle one)

Date Administered: _____/_____/_____ Date Read (if PPD): _____/_____/_____

Result of PPD: _____ mm Result of IGRA test: ☐ Positive ☐ Negative ☐ Indeterminate/Invalid

Type of service provider (i.e. school, Health Steps, other clinics): _____

PPD/IGRA provider: _____ _____
signature printed name

Provider phone number: _____

City _____ County _____

If positive, referral to healthcare provider: ☐ Yes ☐ No

If yes, name/contact of provider: _____

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660),* provide the name of the program and eligibility number: NAME: _____ ELIGIBILITY NUMBER: _____

Check here if no eligibility number ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-_ _ _ _ ❑ I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

Privacy Act Statement:

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

(2) fax: (833) 256-1665 or (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

INSTRUCTIONS FOR
CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM
(CHILD CARE)

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children and household members.
Part 2: List the eligibility number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits. The SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children**.** Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

If some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
Part 2: If the household does not have an eligibility number, skip this part.
Part 3: Applies only to parents/guardians of children in Tier II Day Care Homes. Sponsors must provide the *List of Eligible Federal/State Funded Programs* (H1660), with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.
Part 4: Follow these instructions to report total household income from this month or last month.
Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.
Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.
Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and **other deductions. You should be able to find it on your stub or your boss can tell you.**
Box 2: List the amount each person got from the month from welfare, child support, alimony.
Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, TANF, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.